

Safe Health Care: Are we up to it?



Lucian L. Leape, MD

**Virginians Improving
Patient Care and Safety**

Richmond, VA

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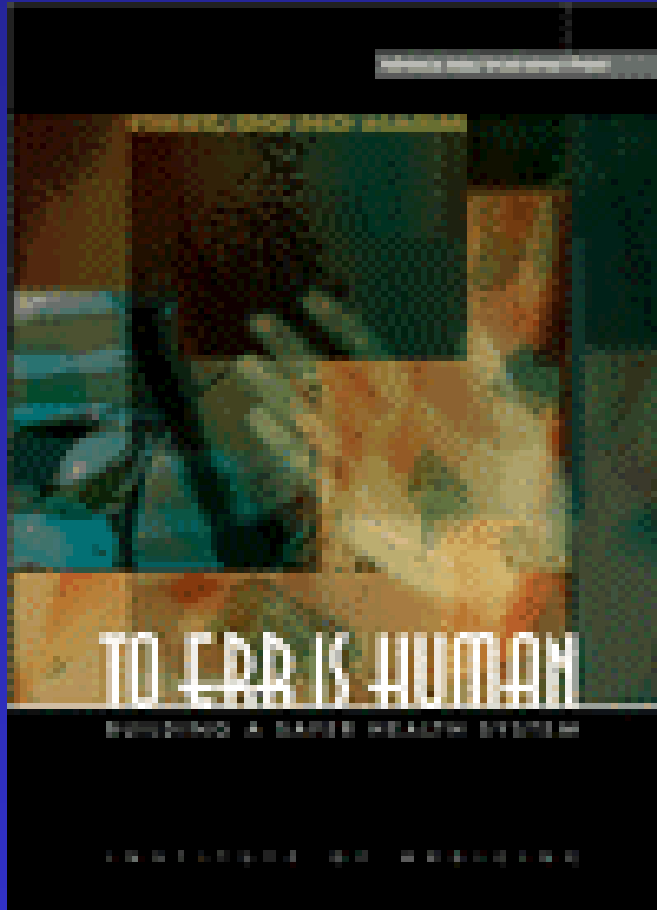
HARVARD SCHOOL OF PUBLIC HEALTH

Safe Health Care: Are we up to it?

1. Safety as a systems problem
2. The Safety Agenda
3. Challenges and opportunities



TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM



Institute of
Medicine
Committee on
Quality of
Health Care in
America

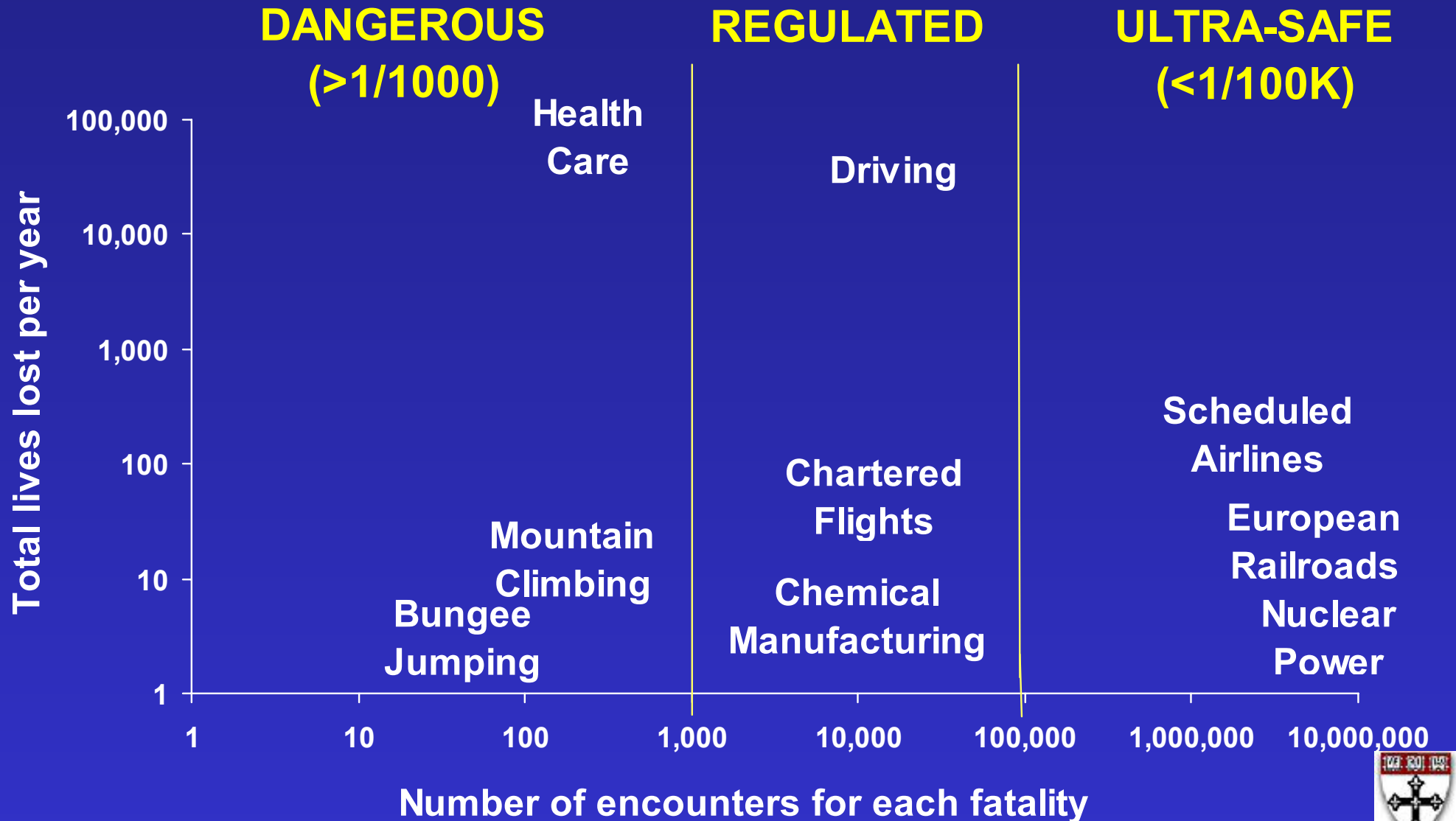


IOM Findings

- **Medical errors are a serious problem**
- **The cause is bad systems**
- **We need to redesign our systems**
- **We need to make safety a national priority**



How Hazardous Is Health Care?



The idea that medical errors are caused by bad systems is a transforming concept



A Transforming Concept

1. Errors are normal behavior
2. The causes of errors are not obscure



Causes of Errors

Habit

Interruptions

Hurry

Fatigue

Anger

Anxiety

Boredom

Fear



A Transforming Concept

1. Errors are normal behavior
2. The causes of errors are not obscure
3. Human errors result from latent errors

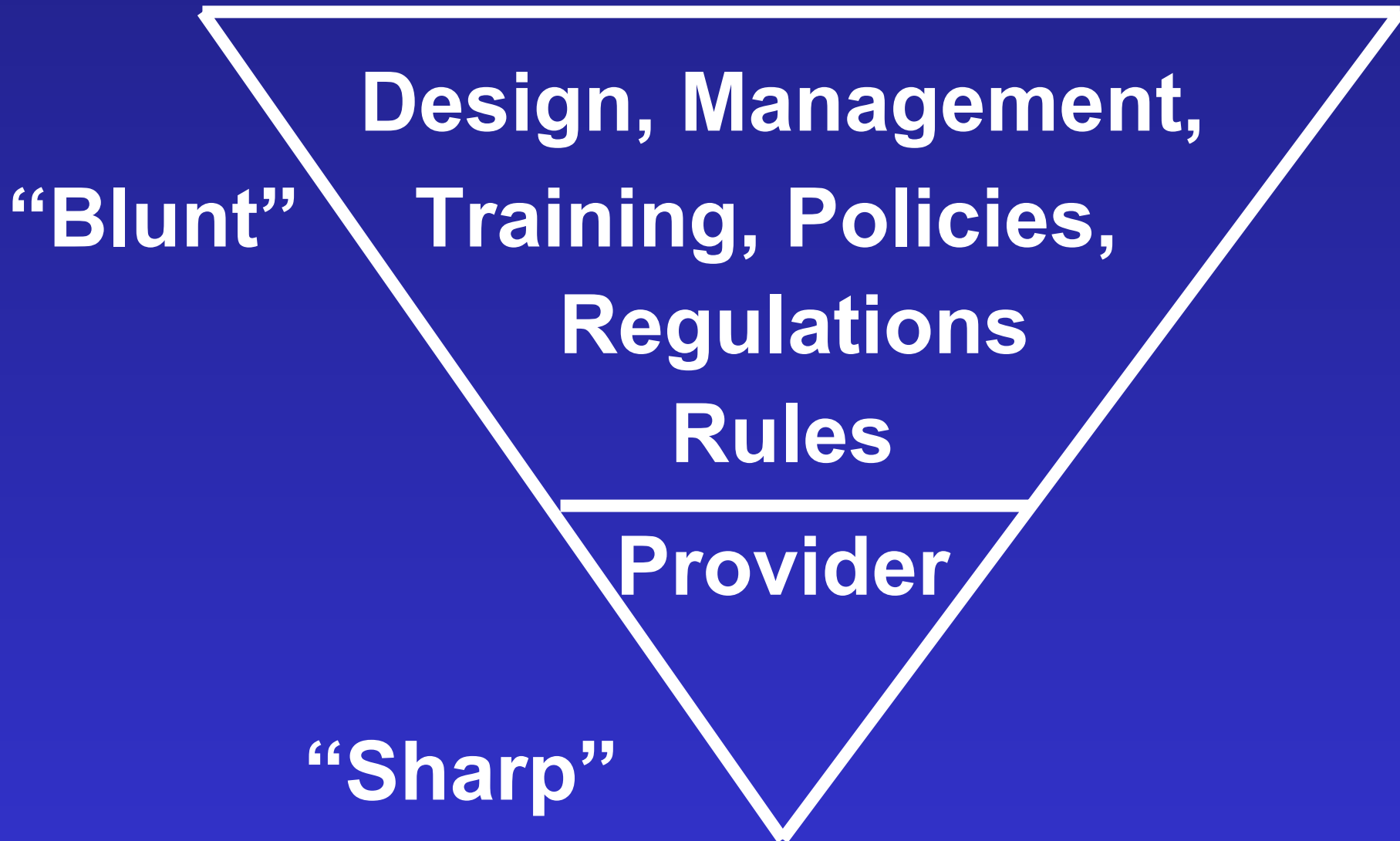


Latent Errors

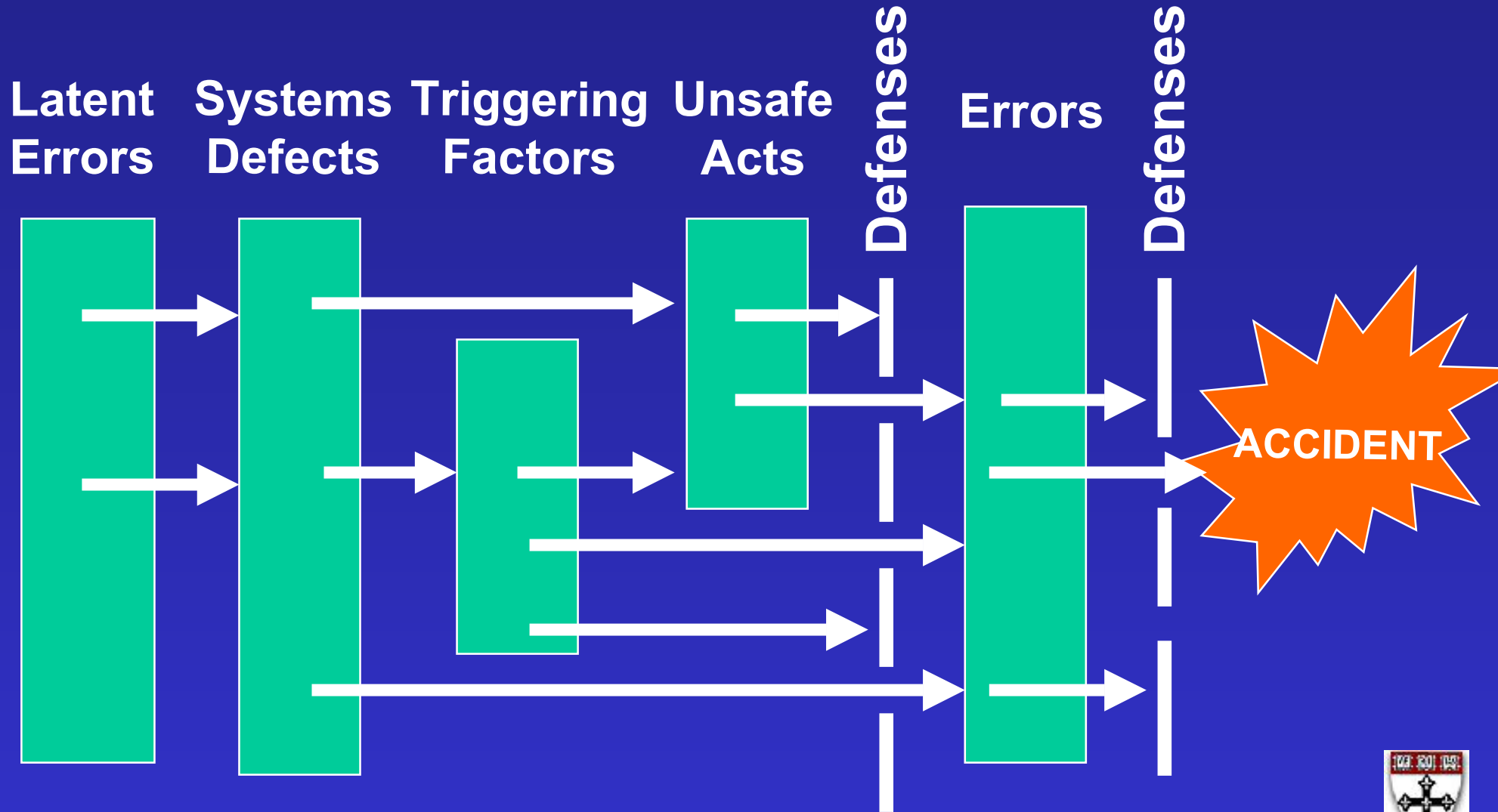
- Design of work
- Conditions of work
- Training
- Design and maintenance of equipment



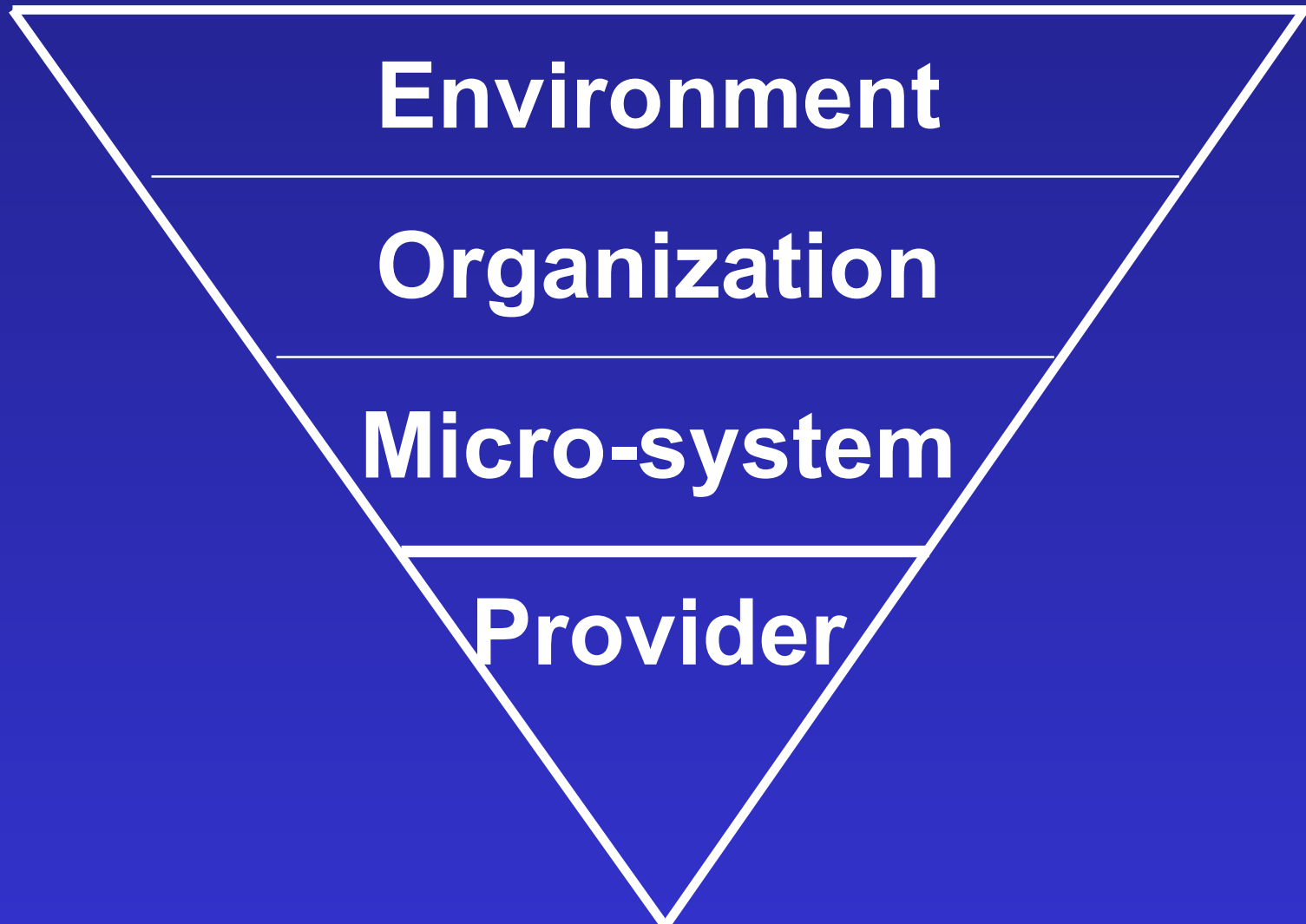
Levels of Safety



Accident Causation Model



Levels of Safety



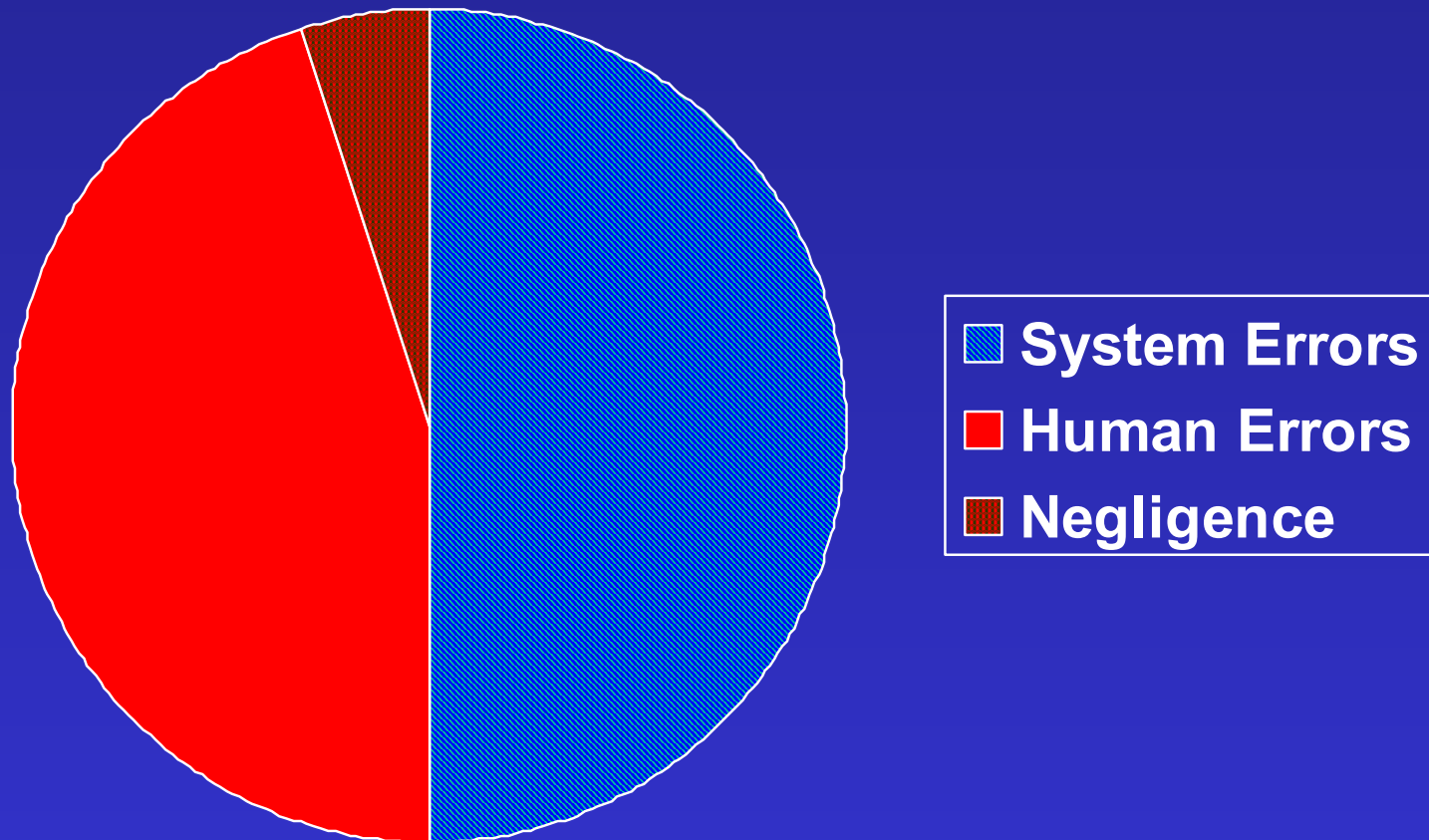
Types of Systems

- **Process, tasks, and equipment**
- **Education and training**
- **Conditions of work**
- **Management and teamwork**
- **Organizational culture**



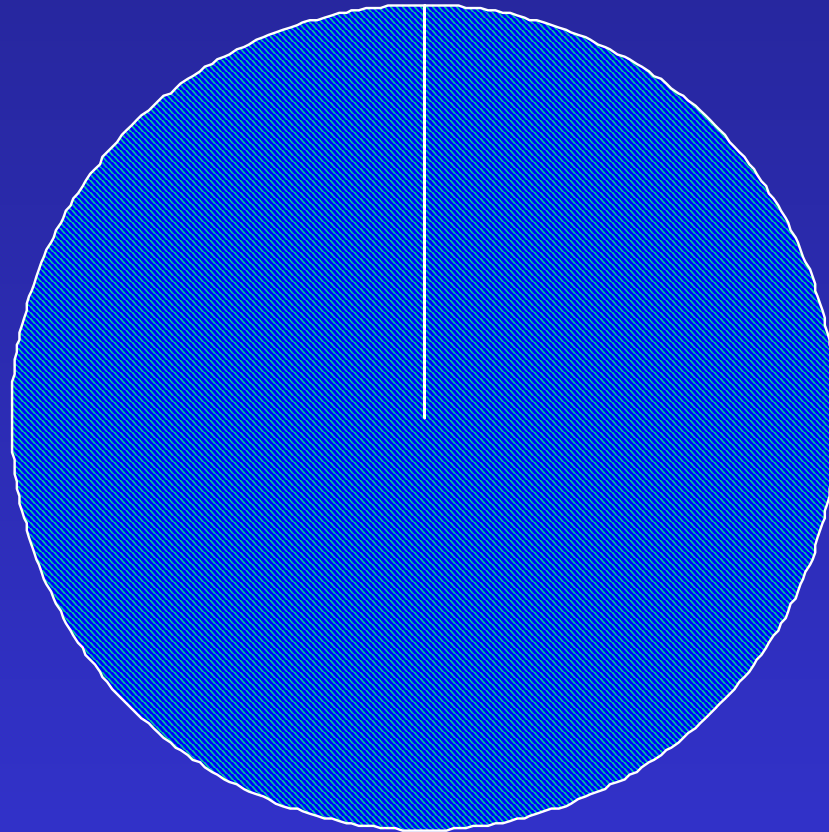
The “Systems” Myth:

There are two kinds of errors:
human errors and systems errors



Reality:

***ALL* errors are system errors.
Human errors are caused by
system errors**



■ System Errors



The Safety Agenda

Implement Best Practices

Change systems

Create a culture of safety

Team training

Education



The Safety Agenda

Improve working conditions



The Real Word

Healthy appearing decrepit 69 year old male, mentally alert but forgetful

The skin was moist and dry

Occasional, constant, infrequent headaches

Patient was alert and unresponsive

Rectal examination revealed a normal sized thyroid

She stated that she had been constipated for most of her life, until she got a divorce



The Safety Agenda

Improve working conditions

Full disclosure

Ensure accountability

Deal with problem doctors



Success Stories

- **Bill Rupp / Roger Resar**
Eau Claire, WI
- **Brock Nelson / Julie Morath**
Minneapolis, MN
- **Paul Uhlig**
Concord, NH



Luther-Midelfort Protocols

- Sliding Scale Insulin
- Hypoglycemia
- Coumadin
- Heparin
- Admission Reconciliation
- Discharge Reconciliation



Luther-Midelfort Protocols

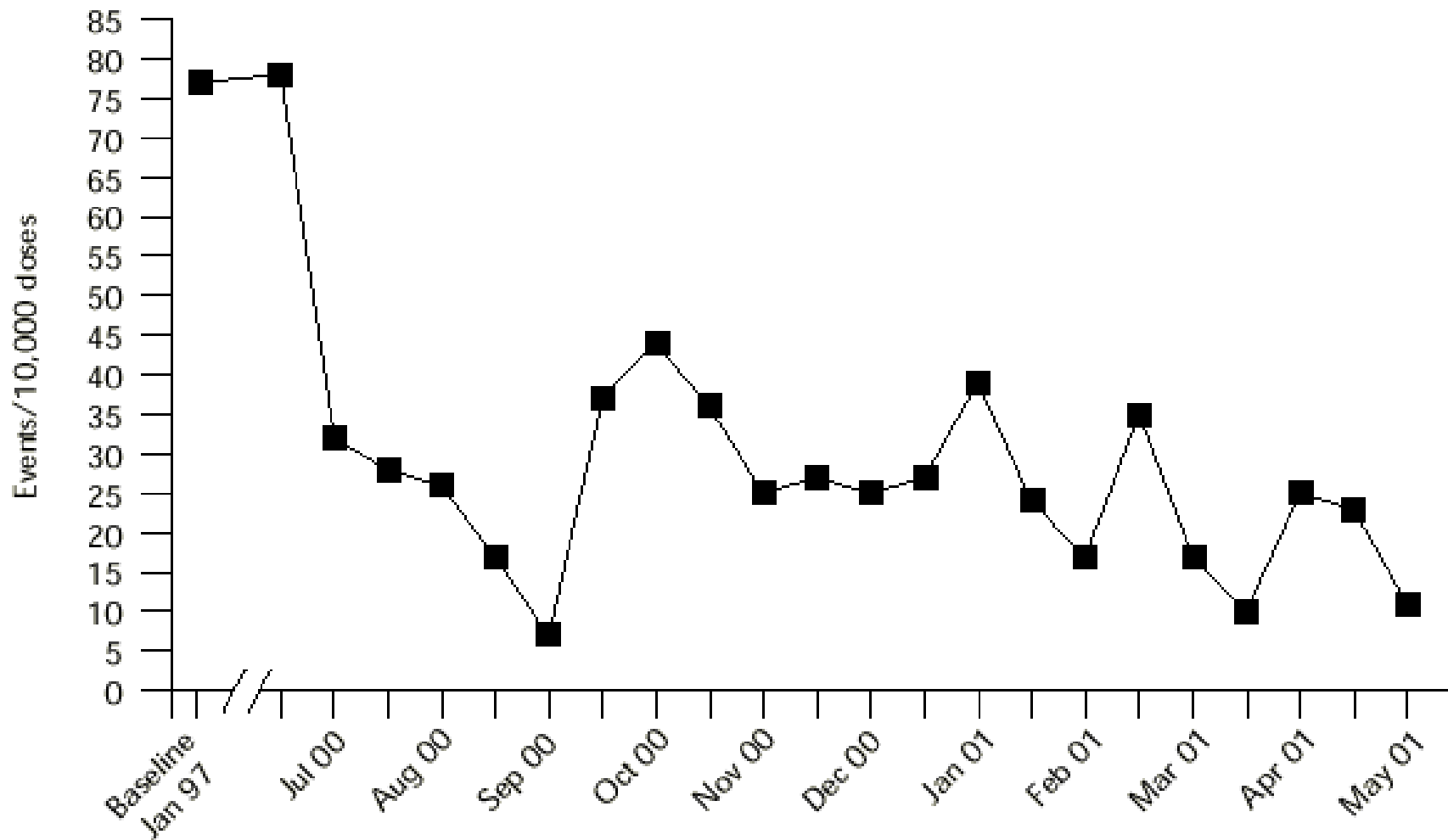
- Renal Dosing
- Potassium Replacement
- Neuromuscular Blockade (Vent)
- Resuming Home Medications
- Pain Management (Vent)
- Sedation (Vent)



Luther-Midelfort Safety

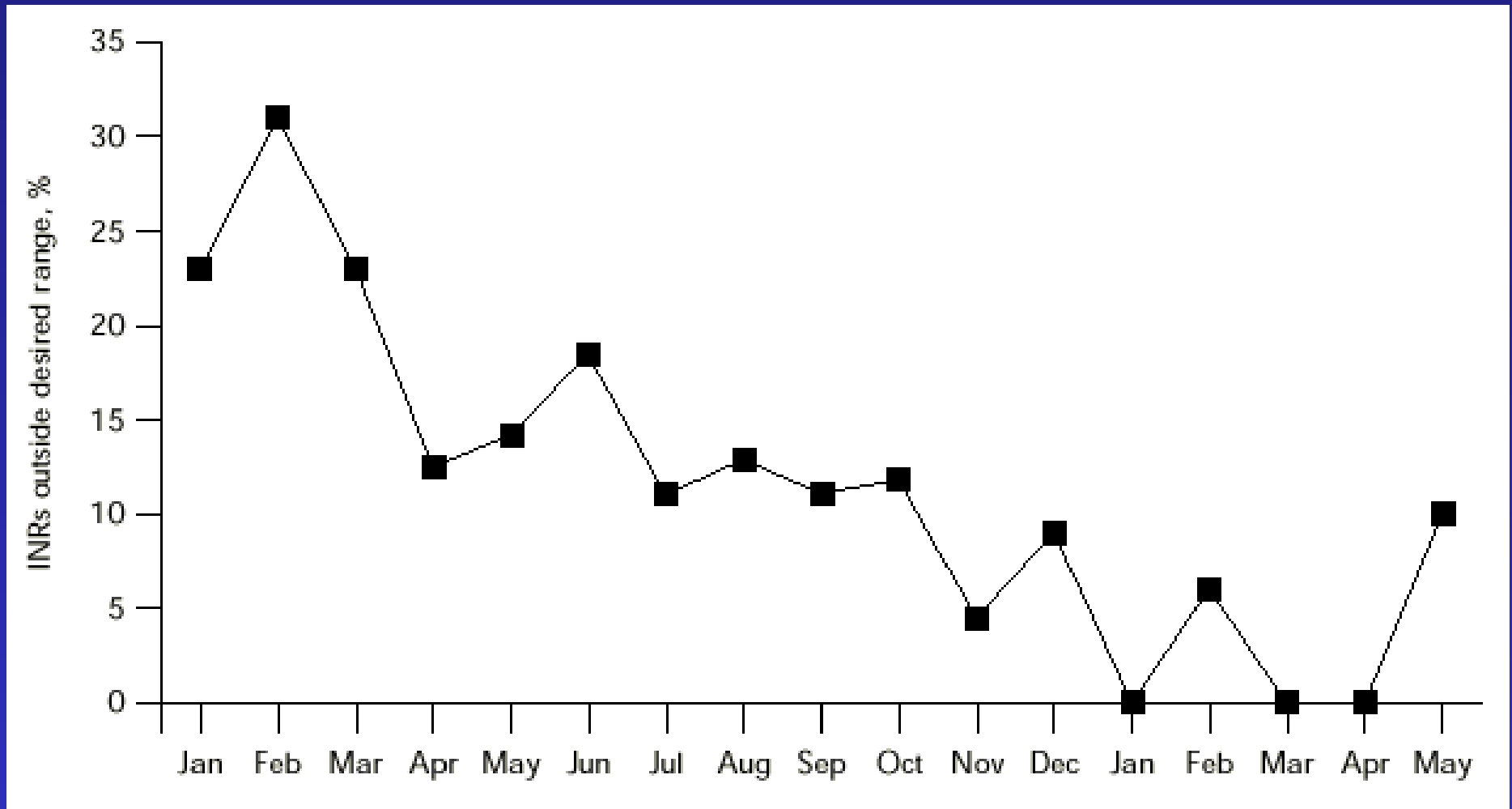
- **Non-punitive Error Reporting**
- **Leadership Training**
- **Videos and Education**
- **Culture Surveys**
- **Principles of Medication Administration**
- **Discharge Medication Calendars**





Adverse drug events at Luther Midelfort from July 2000 to May 2001 compared with baseline rate measured Jan. 1997





Percentage of all international normalized ratio (INR) measurements for coumadin/warfarin that were more than 0.5 above or below the desired range (2.0 to 3.0), Jan. 1998 to May 1999



Minneapolis Children's Hospital Disclosure Policy

- Full, open, timely
- Scripted
- Skillful
- Sensitive
- Hospital takes responsibility
- Support and compensation



The Concord Cardiac Team

- Nurse-Practitioner
- Cardiac Surgeon
- Card Surg Resident
- Physician Assistant
- ICU nurses
- Pharmacist
- Physical Therapist
- Occupational Therapist
- Dietician
- Social worker
- Spiritual care giver
- Outpt Coordinator
- Office nurse
- Patient
- Family members



Concord Cardiac Results

- Patient satisfaction: up
- Employee morale: up
- Surgical complications: down
- Surgical mortality: down



Major Challenges

Shame

Talking about mistakes

Being honest with patients

Challenge to the numbers



Major Challenges

Shame

**Can we learn from the Civil
Rights movement?**



Major Challenges

Shame

Problem Doctors



Problem Doctors

- **Everyone has avoided it:**
 - Hospital boards
 - Management
 - Physicians
- **Highest responsibility of a profession**



The Current System

1. Takes too long
2. Early warning signs are ignored
3. Totally reactive



An Effective Professional Accountability System

- Objective - based on data, not opinion
- Fair - applies to everyone
- Proactive – identifies problem people *before* they hurt someone



Problem Doctors

- Substance abuse - alcohol / drugs
- Psychiatric problems
- Declining competence
- Refusal to follow rules
- Difficult or abusive behavior
- Insensitive with patients



An Effective Professional Accountability System

- Based on performance standards
- Adherence is a condition of employment (and recertification)
- Adherence is monitored
- Employs a wide repertoire of methods for remediation
- Goal: doctor remain in practice

